

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>15C0001172</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>02/23/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>ROC SURGERY LLC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>702 BARNHILL DR STE 201 INDIANAPOLIS, IN 46202</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
S 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 30405 Facility Number: 012397</p> <p>Type of Survey: State Licensure Off Site AAAHC Accreditation Survey</p> <p>Date of AAAHC On Site Survey - ASC full survey February 22-23, 2012</p> <p>Date of ISDH off site review - April 11, 2012</p> <p>Reviewer/Surveyor - Deborah Franco RN, PHNS</p> <p>Based on review of the February 22-23, 2012 AAAHC Accreditation Survey Report, it has been determined that ROC Surgery meets the requirements for ASC Licensure in Indiana.</p>	S 000			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1